IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF KANSAS

STELLA C. SMITH	)	
	)	
Plaintiff,	)	
	)	
	)	
v.	)	Case No. 04-1132-WEB
	)	
	)	
JO ANNE B. BARNHART,	)	
Commissioner of the	)	
Social Security Administration	)	
	)	
Defendant.	)	

MEMORANDUM AND ORDER

Plaintiff seeks judicial review of the Defendant's decision to deny Disability Insurance benefits under Title II and supplemental security income (SSI) benefits based on a disability under Title XVI. See 42 U.S. C. .§ § 1381 et seq. A review of the record reveals that plaintiff filed for these benefits on December 7, 2001 reporting an inability to work since September 17, 1996. (R. at 18). A hearing was held in front of administrative law judge (ALJ) Dayton on February 26, 2003. Id. At the time of the hearing plaintiff was 51 years old. (Id. at 19). The ALJ followed the five-step sequential analysis found at 20 C.F.R. § 404.1520. (Id.).

According to the ALJ, the medical evidence established that plaintiff has medically determinable severe impairments of diabetes mellitus with peripheral neuropathy, GERD (gastroesophageal reflux disorder), and short bowel syndrome status/post multiple surgeries. (Id. at 20). Next he found that plaintiff's severe impairments did not meet or exceed the criteria for any of the listed impairments in 20

C.F.R. Part 404, Subpart P, Appendix 1. (Id. at 22). Next, the ALJ found plaintiff's impairments do not preclude her from doing past work. (Id. at 27). A VE testified that plaintiff's RFC (residual functional capacity) allowed for light and sedentary work and there are substantial numbers of those jobs in the national economy. (Id.). A decision denying plaintiff benefits was issued on April 21, 2003. (Id. at 29).

Plaintiff argues the ALJ erred on multiple occasions. First, the ALJ failed to develop the record. Second, the ALJ failed to evaluate plaintiff's credibility correctly. Third, the ALJ failed to incorporate plaintiff's diarrhea in the hypothetical question posed to the Vocational Expert (VE). Finally, the ALJ failed to list diarrhea as a non-exertional impairment in step two of the sequential evaluation.

I. Standard

The Court must affirm the Commissioner's final decision if it is supported by substantial evidence. 42 U.S.C. § 405(g); *White v. Barnhart*, 287 F.3d 903, 905 (10th Cir. 2002). Substantial evidence is 'more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Casias v. Secretary of HHS*, 933 F.2d 799, 800 (10th Cir. 1991) quoting *Richardson v. Perales*, 402 U.S. 389, 401 (1971). Our role is not to reweigh the evidence or substitute our judgment for that of the Commissioner. *White*, 287 F.3d at 905. The Commissioner's decision is not subject to such deference and reversal may be appropriate if the Commissioner applied an incorrect legal standard. *Casias*, 933 F.2d at 801.

The Social Security Act provides that an individual shall be determined to be under a disability only if the claimant can establish that they have a physical or mental impairment expected to result in death or last for a continuous period of twelve months which prevents the claimant from engaging in substantial

gainful activity (SGA). 42 U.S.C. § 423(d)(1)(A). The claimant's physical or mental impairments must be of such severity that they are not only unable to perform their previous work but cannot, considering their age, education, and work experience, engage in any other kind of SGA which exists in the national economy. 42 U.S.C. § 423(d)(2)(A).

The Commissioner has established a five-step sequential evaluation process to determine disability . If at any step a finding of disability or non-disability can be made, the Commissioner will not review the claim further. 20 C.F.R § 404.1520(a)(4). At step one, the agency will find non-disability if claimant is engaged in SGA. 20 C.F.R § 404.1520(a)(4)(i). At step two, the claimant must show a severe disability. 20 C.F.R § 404.1520(a)(4)(ii). A severe disability is defined as an impairment which significantly limits a claimant's physical or mental ability to do basic work activity. 20 C.F.R § 404.1520(c). At step three, the agency determines whether the severe impairment meets or equals the impairments and the duration requirements in Appendix 1 of 20 C.F.R. and if it does, the claimant will be found disabled. 20 C.F.R § 404.1520(a)(4)(iii). If the impairment does not meet the standards in step three, the agency continues to step four and assesses whether the claimant can do her previous work and if so, then she will not be disabled. 20 C.F.R § 404.1520(a)(4)(iv). At step five, the agency considers a claimant's RFC, age, education and past work experience to determine if claimant is capable of performing other work in the national economy. 20 C.F.R § 404.1520(a)(4)(v).

The claimant bears the burden of proof through step four of the analysis. *Nielson v. Sullivan,* 992 F.2d 1118, 1120 (10th Cir. 1993). At step five, the burden shifts to the agency. *Id.* Before going from step three to step four, the agency must assess the claimant's RFC. 20 C.F.R § 404.1520(a)(4).

II. Duty to Develop the Record

The ALJ has a basic duty to inform himself about the facts relevant to his decision and to obtain material evidence. 20 C.F.R. § 404.944. "The ALJ has the duty to develop the record by obtaining pertinent, available medical records which come to his attention during the course of the hearing." *Carter v. Chater*, 73 F.3d 1019, 1022 (10th Cir. 1996). However, the Plaintiff also "must furnish medical and other evidence that we can use to reach conclusions about your medical impairments..." 20 C.F.R. § 404.1512(a). Additionally, an ALJ is under an obligation to order a consultative examination when additional evidence is needed if there is "some objective evidence in the record suggesting the existence of a condition which could have a material impact on the disability decision requiring further investigation." *Hawkins v. Chater*, 113 F.3d 1162, 1167 (10th Cir. 1997); 20 C.F.R. § 404.1519(b)(1-5).

Plaintiff argues that the ALJ did not comply with his duty to develop the record because: 1)other than two reports of gastric biopsies from Dr. Rausa, there are no other treatment notes in the record from this physician and 2) there are no records from Dr. Crook, who was the doctor to whom Dr. Rausa reported. Plaintiff cites a letter from Dr. Rausa that spoke of a follow up appointment on 5/15/01. (R. 142, 178). There is no documentation in the record regarding this follow up appointment.

Plaintiff had an appointment on 5/10/01 with Dr. Rausa to perform a gastric emptying study. (Id. at 142). The results were printed in a form on 5/11/01. (Id. at 143). Dr. Rausa performed a gastric emptying study as a result of complaints of nausea and vomiting, not diarrhea. (Id. at 142). Dr. Rausa's letter shows that the follow up appointment on 5/15/01 concerned the results of plaintiff's gastric emptying study. (Id. at 178). Plaintiff has failed to show the relevance of this record in considering plaintiff's diarrhea condition.

Plaintiff argues that there are no records from Dr. Crook. The record does reveal that Dr. Crook performed a mammography for plaintiff. (Id. at 240). Once again plaintiff fails to state the relevance of this record to plaintiff's diarrhea condition. The ALJ had no duty to seek out these additional records because they are not pertinent or relevant to his decision. 20 C.F.R. § 404.944; See *Hawkins*, 113 F.3d at 1168 (The duty to develop the record is limited to material issues).

Additionally, the Secretary ordered a consultative examination which was performed by a physician in May 11, 2002. (Id. at 203). A consultative exam is not required unless the record establishes that such an exam is necessary to enable the ALJ to make a disability decision. *Turner v. Califano*, 563 F.2d 669, 671 (5th Cir. 1977); See also *Robertson v. Chater*, 900 F. Supp. 1520, 1530 (D. Kan. 1995). The Secretary took measures to ensure the record was developed for the ALJ and plaintiff's argument is without merit.

III. Credibility Analysis

Plaintiff argues that the ALJ failed to conduct a proper credibility analysis because he: a) failed to account for plaintiff's lack of insurance as a reason why she did not seek medical treatment; b) erred when stating there was a lack of objective medical evidence showing chronic diarrhea; c) misstated the evidence because plaintiff's weight has not been stable; and d) relied too much on plaintiff's daily activities. These errors allegedly resulted in an incorrect determination of plaintiff's RFC.

> In recognition of the fact that an individual's symptoms can sometimes suggest a greater level of severity of impairment than can be shown by the objective medical evidence alone, 20 C.F.R. 404.1529(c) and 416.929(c) describe the kinds of evidence, including the factors below, that the adjudicator must consider in addition to the objective medical evidence when assessing the credibility of an individual's statements:

1. The individual's daily activities;
2. The location, duration, frequency, and intensity of the individual's pain or other symptoms;
3. Factors that precipitate and aggravate the symptoms;
4. The type, dosage, effectiveness, and side effects of any medication the individual takes or has taken to alleviate pain or other symptoms;
5. Treatment, other than medication, the individual receives or has received for relief of pain or other symptoms;
6. Any measures other than treatment the individual uses or has used to relieve pain or other symptoms (e.g., lying flat on his or her back, standing for 15 or 20 minutes every hour, or sleeping on a board); and
7. Any other factors concerning the individual's functional limitations and restrictions due to pain or other symptoms. SSR 96-7p.

The ALJ stated in his decision that, "[t]he claimant's testimony of constant unremitting diarrhea since September, 1996 that prevents her from working and from leaving home is not credible considering her failure to seek treatment for this disorder, her frequent denial of diarrhea to medical sources, and the claimant's actual activity level." (R. at 24).

a. Evidence of Medical Treatment for Diarrhea

Plaintiff argues that she did not deny her diarrhea to medical sources and did seek treatment for this impairment. The plaintiff states that she mentioned or sought treatment for diarrhea in the following instances:

1) To the consulting psychologist, Dr. Simmonds on April 11, 2002 that her diarrhea had become intense and without warning. (Id. at 181).

2) To the consulting physician, Dr. Henderson, that she can have 10-12 bowel movements daily. (Id. at 203).

3) At the hearing, she stated she has diarrhea every other day. (Id. at 345).

4) On the agency Reconsideration Disability Report, she stated that she cannot leave the house due to diarrhea. (Id. at 104).

5) To Dr. Lehr in 1995, plaintiff complained of abdominal pain and nausea. (Id. at 136).

The ALJ relied on other evidence including:

1) Plaintiff stated she stopped working in 1996 because of pain and diarrhea and that a colostomy bag had been recommended by a physician; however, the medical records for 1996 show two visits for gastritis and mention neither diarrhea nor a recommendation for a colostomy bag. (Id. at 24, 136).

2) Plaintiff denied diarrhea during emergency room visits in March and September of 2002 (Id. at 24, 210, 233).

3) Plaintiff complained of constipation during an emergency room visit in February 2002. (Id. at 24, 244).

4) Plaintiff did not mention diarrhea to medical personnel during emergency room visits in January and May 2002. (Id. at 24, 225).

The Court notes that plaintiff did mention diarrhea during a hospital visit in January 2002. (Id. at 258). Also, Dr. Lehr attributed plaintiff's abdominal pain not to diarrhea but to gastritis. (Id. at 136).

A strong indication of credibility is "[t]he degree to which the individual's statements are consistent with the medical signs and laboratory findings and other information provided by medical sources, including information about medical history and treatment". SSR 96-7p.

The ALJ did not err by including the denial of diarrhea to medical personnel as a part of the credibility analysis because the severity of plaintiff's diarrhea is not consistent with the medical evidence. Plaintiff complains having over 10 bowel movements per day approximately every 30 minutes and in total spending more three hours in the bathroom every other day due to diarrhea. (R. at 344, 346). Plaintiff also

complains she has suffered from diarrhea since 1996. (Id. at 337). The denial of diarrhea during hospital visits is inconsistent with plaintiff's statements regarding the severity of her diarrhea. The ALJ correctly considered these factors in the credibility analysis.

Plaintiff contends that the ALJ's analysis was faulty because he did not consider the plaintiff's lack of medical insurance for her failure to seek medical treatment for her diarrhea.

> [b]efore the ALJ may rely on the claimant's failure to pursue treatment or take medication as support for his determination of noncredibility, he or she should consider (1) whether the treatment at issue would restore claimant's ability to work; (2) whether the treatment was prescribed; (3) whether the treatment was refused; and, if so, (4) whether the refusal was without justifiable excuse. *Thompson v. Sullivan*, 987 F.2d 1482, 1490 (10th Cir. 1993) quoting *Frey v. Bowen*, 816 F.2d 508, 517 (10th Cir. 1987) (internal quotations and citations omitted).

The ALJ does not need to address the *Frey* test because this is not a case where plaintiff failed to follow a prescribed treatment but rather it is a failure to seek medical attention. "[T]he *Frey* test does not apply to the issue of failure to seek relief..." *See Jesse v. Barnhart*, 323 F. Supp. 2d 1100, 1108-1109 (D. Kan. 2004); see also *Qualls v. Apfel*, 206 F.3d 1368, 1372-1373 (10th Cir. 2000). There is no evidence that any doctor prescribed any treatment for plaintiff's diarrhea and she testified only to taking over the counter Imodium AD. (R. at 345). While plaintiff states that she mentions diarrhea to her treating nurse practitioner every time she sees her, there is no objective medical evidence to substantiate her claim. (Id.). Therefore, the ALJ properly evaluated plaintiff's failure to seek medical attention in the credibility analysis and was not required to use the *Frey* factors.

Furthermore, plaintiff's statements about lacking insurance are inconsistent with her hospital visits. The record shows that plaintiff sought medical treatment for diabetes and other impairments 13 times in 2002 and 2003. (Id. at 24, 210, 233, 244, 274, 275, 276, 277, 279, 280, 291, 297, 299, 299A).

Therefore, plaintiff's statement that she lacked medical insurance or money to seek treatment for diarrhea is incredible. Plaintiff did seek medical treatment yet inexplicably failed to mention diarrhea; therefore, substantial evidence supports the ALJ use of this factor in his credibility determination.

b. Lack of Objective Medical Evidence

"Objective evidence 'is a useful indicator to assist us in making reasonable conclusions about the intensity and persistence of an individual's symptoms and the effects those symptoms may have on the individual's ability to function." SSR 96-7p quoting 20 C.F.R. 404.1529(c)(2). "When present, these [medical] findings tend to lend credibility to an individual's allegations about pain or other symptoms and their functional effects." SSR 96-7p. Additionally, "[t]he absence of an objective medical basis which supports the degree of severity of subjective complaints is just one factor to be considered in evaluating the credibility of the testimony and complaints." *Luna v. Bowen*, 834 F.2d 161, 165 (10th Cir. 1987) (internal citations omitted). The ALJ cited the above regulations before applying them to plaintiff's case. (R. at 23).

Plaintiff argues that diarrhea's absence in treatment notes does not prove that it does not exist. There are records from the Hunter Health Clinic showing visits on ten different days labeled "Diabetes Progress Notes" or "Progress Notes" from 7/27/01 to 1/30/03. (Id. at 274, 275, 276, 277, 279, 280, 291, 297, 299, 299A). None of these mention anything about diarrhea despite the fact that plaintiff allegedly told the doctor about her diarrhea "every time I go in to see her". (Id. at 345).

The plaintiff attempts to bolster her position by citing to the record which show other hospital visits including: 1) 1/27/01 - stomach emptying problem, GERD, short bowel syndrome; 2) 1/02 - abdominal

and sternum pain; 3) 2/02 - stomach emptying and nausea; 4) 4/02 - abdominal pain, nausea and an inability to eat; and 5) 5/23/02 - GERD. (R. at 157, 257, 243, 218, 280). While there is a brief note stating that plaintiff had diarrhea one time on 5/23/02, the other treatment notes do not mention diarrhea. (Id. at 258). Plaintiff fails to explain how these hospital visits "focus on plaintiff's diarrhea". (Pl. br. at 8). The lack of objective medical evidence regarding plaintiff's diarrhea is supported by the record and the ALJ did not err by considering it in his credibility determination.

c. Unreliable Weight Statements

Plaintiff next attacks the ALJ's reliance on alleged exaggerated statements. Plaintiff stated to a consultative physician in May 2002 that she weighed 120 pounds a year ago. (Id. at 203). Plaintiff also stated at the hearing, in February 2003, that a year ago she was really sick and weighed 130 pounds. (Id. at 335). The ALJ stated that the records show plaintiff's weight has been stable over a period of years from 168 pounds in May 1996 to161 pounds in June 2001 to 166 pounds in February 2002 and that her statements of fluctuating weight are unreliable. (Id. at 24). At the hearing, plaintiff stated she weighed 175 pounds. (Id. at 335).

Plaintiff attempts to show that the ALJ erred because plaintiff's weight was not stable because at times plaintiff weighed up to 185 pounds in January 2003 and 179 pounds in April 2002. Other than plaintiff's statements, there is nothing to substantiate her allegations of weighing 120-130 pounds. Plaintiff's statements about her weight, when compared to the medical record, support the ALJ's ultimate credibility conclusion that plaintiff's allegations are "exaggerated and not reliable." (Id. at 25).

d. Daily Activities

Plaintiff finally argues that the ALJ erred when evaluating credibility because he relied too much on plaintiff's daily activities. While evidence that a claimant engages in limited activities does not establish an ability to work, such evidence may be considered along with other evidence, in considering entitlement to disability benefits. *Gossett v. Bowen*, 862 F.2d 802, 807 (10th Cir. 1988).

The ALJ found that plaintiff's ability to cook daily meals, spend 7-10 hours a week caring for grandchildren, do laundry and other chores, mow the lawn, shop for groceries, attend church, and leave home to care for her ill mother are inconsistent with plaintiff's testimony that she spends three days in bed every two weeks due to headache pain and is unable to leave the house due to the need for constant bathroom access. (R. at 23, 346-350).

The Court finds that the ALJ's use of plaintiff's daily activities in evaluating plaintiff's disabling diarrhea is appropriate because, as discussed earlier, he also relied on other evidence to make his ultimate credibility determination. See *Patterson v. Apfel*, 62 F. Supp. 2d 1212, 1218 (D. Kan. 1999) (In evaluating the credibility of the claimant, an ALJ must consider and weigh a number of factors in combination). The ALJ's credibility determination must be upheld as it is supported by and specifically linked to substantial evidence in the record. *Casias*, 933 F.2d at 801 (We defer to the ALJ as trier of fact, the individual optimally positioned to observe and assess witness credibility).

IV. The ALJ's examination of the VE

Plaintiff argues that the ALJ failed to incorporate plaintiff's diarrhea into the hypothetical question posed to the VE. The ALJ found that plaintiff's allegations of disabling diarrhea were not credible for

reasons already discussed. (R. at 24). "In formulating a hypothetical question, the administrative law judge need rely only on those impairments supported by substantial evidence in the record." *Patterson v. Apfel*, 62 F. Supp. 2d 1212, 1218 (D. Kan. 1999); *cf. Evans v. Chater*, 55 F.3d 530, 532 (10th Cir. 1995) (ALJ's failure to include carpal tunnel impairment into hypothetical to the VE was error because the agency had previously acknowledged claimant's impairment which was supported by substantial evidence). As discussed previously, plaintiff's allegations of intense diarrhea are not supported by substantial evidence; therefore, the ALJ was not required to include this impairment in the hypothetical question to the VE.

V. Step Two

Plaintiff contends that the ALJ erred because he failed to list her diarrhea as a nonexertional impairment at Step 2. The analysis at step two does not evaluate whether an impairment is exertional or nonexertional; but rather, it involves an analysis if the impairment is severe or not.

At step two, the ALJ must apply a de minimus standard to determine whether an impairment significantly limits the claimant's ability to do basic work activity. *Williams v. Bowen*, 844 F.2d 748, 751 (10th Cir. 1988); *Hawkins v. Chater*, 113 F.3d 1162, 1169 (10th Cir. 1997); 20 C.F.R. § 404.1520(c). "A determination that an individual's impairment(s) is not severe requires a careful evaluation of the medical findings that describe the impairment(s) (i.e., the objective medical evidence and any impairment-related symptoms)...". SSR 96-3p.

The ALJ stated that plaintiff had three severe impairments, including short bowel syndrome status/post multiple surgeries. (R. at 20). As plaintiff stated in her brief, diarrhea, cramping, heartburn are symptoms of short bowel syndrome, which is a common condition after removing part of the small intestine.

(Pl. Reply Br. at 2). The ALJ discussed plaintiff's diarrhea, abdominal pain, and the removal of part of her intestine in the paragraph preceding the listing of severe impairments. (R. at 20). While the ALJ did not list diarrhea separately as a severe impairment, the discussion of plaintiff's diarrhea properly accounted for it as a symptom of short bowel syndrome.

VI. Support for RFC

Plaintiff argues that the RFC is not supported by the evidence. While an ALJ will consider medical opinions, the ultimate RFC determination is reserved for the Commissioner. 20 C.F.R. § 404.1527(e)(2).

> The RFC assessment must be based on all of the relevant evidence in the case record, such as:
> -Medical history,
> -Medical signs and laboratory findings,
> -The effects of treatment, including limitations or restrictions imposed by the mechanics of treatment (e.g., frequency of treatment, duration, disruption to routine, side effects of medication),
> -Reports of daily activities,
> -Lay activities
> -Recorded observations
> -Medical source statements,
> -Effects of symptoms, including pain, that are reasonably attributed to a amedically determinable impairment,
> -evidence from attempts to work
> -Need for a structured living environment, and
> -Work evaluations, if available. SSR 96-8p.

The ALJ stated that the RFC incorporates all of the credible limitations including nonsevere impairments. (R. at 25). The ALJ cited medical recommendations that plaintiff get increased exercise and activity. (Id. at 23, 291). The ALJ linked the RFC to specific medical findings that plaintiff walks with a normal gait with no assistive device, no difficulty getting on or off the table and only mild difficulty heel to toe walking, squatting, hopping, and arising from a sitting position. (Id. at 23, 205). The ALJ also considered plaintiff's

daily activities and stated that these activities indicate that she would be able to control her diarrhea sufficiently to maintain work activity. (Id. at 23, 115-117). The ALJ appropriately considered plaintiff's mental impairments, as he found plaintiff was depressed but did suffer from any functional limitations from depression.

In the RFC analysis, the ALJ did not err by not giving controlling weight to the treating nurse practitioner's opinion because nurse practitioners are not listed as acceptable medical sources who can provide evidence of an impairment. 20 C.F.R. § 404.1513(a); See also *Nichols v. Commissioner of the SSA*, 260 F. Supp. 2d 1057, 1066 (D. Kan. 2003) (Nurse practitioner is not an acceptable medical source). However, the ALJ may use evidence from other medical sources, including nurse practitioners. 20 C.F.R. § 404.1513(d)(1). The ALJ chose not to accord substantial weight to the nurse practitioner's opinion because it was inconsistent with other objective medical evidence as well as plaintiff's daily activities. (R. at 26). The ALJ provided a cogent explanation linking plaintiff's RFC to substantial evidence; therefore, plaintiff's claims are without merit.

It is therefore ORDERED that Plaintiff's appeal from the decision of the Commissioner of Social Security (Doc. 7) be DENIED and the decision of the Commissioner of Social Security be AFFIRMED.

SO ORDERED this 8th day of February 2005.

s/ Wesley E. Brown
Wesley E. Brown, U.S. Senior District Judge